| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
| *Company Tracking Number:* | | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

## Filing at a Glance

Company: Physicians Life Insurance Company

| | | |
|---|---|---|
| Product Name: ULA29AR-1 INFORMATION FILING | SERFF Tr Num: PHYS-125894661 | State: ArkansasLH |
| TOI: MS06 Medicare Supplement - Other | SERFF Status: Closed | State Tr Num: 40820 |
| Sub-TOI: MS06.000 Medicare Supplement - Other | Co Tr Num: | State Status: Approved-Closed |
| Filing Type: Form | Co Status: | Reviewer(s): Stephanie Fowler |
| | Author: Kathryn Gurnett | Disposition Date: 11/12/2008 |
| | Date Submitted: 11/10/2008 | Disposition Status: Approved |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: ULA29AR-1 INFORMATION FILING | Status of Filing in Domicile: Authorized |
| Project Number: ULA29AR-1 INFORMATION FILING | Date Approved in Domicile: 05/22/2008 |
| Requested Filing Mode: Informational | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: Resubmission | Previous Filing Number: PHYS-125825381 |
| Group Market Size: | Overall Rate Impact: |
| Group Market Type: | Filing Status Changed: 11/12/2008 |
| Explanation for Other Group Market Type: | |
| State Status Changed: 11/12/2008 | Deemer Date: |

Corresponding Filing Tracking Number:

Filing Description:

NAIC #72125 FEIN: 47-0529583

Individual Medicare Supplement

Informational Filing

ULA29AR-1 Application

Previously approved form SERFF #PHYS-125825831, State Tracking #40308

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
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| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

Approved 10-1-08

Upon review of the above captioned form, it was found that the fraud warning was inadvertently omitted from the form. This has been added to the form and is attached. The form has not been used yet. No other changes were made to this form.

If you have any questions please contact me.

Sincerely,

Kathryn R. Gurnett, MBA, CPCU, CLU, HIA, AAPA, AIRC, FLMI, CCP
Policy Approval and Compliance Coordinator
Government and Industry
Voice: (402) 633-1188
Fax: (402) 633-1096
E-mail: katie.gurnett@physiciansmutual.com

## Company and Contact

**Filing Contact Information**

| | | |
|---|---|---|
| Kathryn Gurnett, Policy Approval & Compliance Coordinator | katie.gurnett@physiciansmutual.com | |
| 2600 Dodge Street | (402) 633-1188 [Phone] | |
| Omaha, NE 68131 | (402) 633-1096[FAX] | |

**Filing Company Information**

| | | |
|---|---|---|
| Physicians Life Insurance Company | CoCode: 72125 | State of Domicile: Nebraska |
| 2600 Dodge Street | Group Code: 367 | Company Type: |
| Omaha, NE 68131 | Group Name: | State ID Number: |
| (402) 633-1188 ext. [Phone] | FEIN Number: 47-0529583 | |
| | --- | |

## Filing Fees

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
| *Company Tracking Number:* | | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $20.00 |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Physicians Life Insurance Company | $20.00 | 11/10/2008 | 23812340 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
| *Company Tracking Number:* | | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved | Stephanie Fowler | 11/12/2008 | 11/12/2008 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
| *Company Tracking Number:* | | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

# Disposition

Disposition Date: 11/12/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
| *Company Tracking Number:* | | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Certification/Notice | | No |
| **Supporting Document** | Application | | No |
| **Supporting Document** | Health - Actuarial Justification | | No |
| **Supporting Document** | Outline of Coverage | | No |
| **Form** | APPLICATION | Approved | No |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
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| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

# Form Schedule

**Lead Form Number:** ULA29AR-1

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved | ULA29AR-1 | Application/ Enrollment Form | APPLICATION | Revised | Replaced Form #: ULA29AR-1 Previous Filing #: PHYS-125825381 | | ULA29AR-1.pdf |

# Medicare Supplement Application to
# PHYSICIANS LIFE INSURANCE COMPANY© 2600 Dodge Street • Omaha, Nebraska 68131

Policy No. _____ Source I.D. _____

Please print the following information.

Applicant's Name _____ Date of Birth _____
First Middle Initial Last Mo. Day Yr.

Street Address _____ Apt. _____ Age _____ Sex _____ Height _____ Weight _____

City _____ State _____ Zip _____ Phone No. ( ) _____
Area Code

E-mail address _____

Applicant's Medicare Health Insurance Claim Number (H I C N) _____
*(exactly as shown on your Medicare card)*

☐ Annual ☐ Quarterly
☐ Semi-annual ☐ Monthly
☐ ABW TYPE [1]

Date of Application _____ Effective Date ___/___/___ $ Premium Collected _____ $ Modal Premium _____

**Have you used tobacco products in the past 12 months? ☐ Yes ☐ No**
(Under Open Enrollment, You Are Not Required To Answer This Question)

Type of coverage applied for:

☐ **PLAN A/L260** ☐ **PLAN B/L261** ☐ **HIGH DEDUCTIBLE PLAN F/L267** ☐ **PLAN G/L266**

☐ **PLAN F/L265 <u>WITHOUT</u> HIGH DEDUCTIBLE PREMIUM DISCOUNT RIDER/LR143**

**Rate Structure (10)**

☐ **PLAN F/L265 <u>WITH</u> HIGH DEDUCTIBLE PREMIUM DISCOUNT RIDER/LR143**

**Rate Structure (20)**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

| **To the best of your knowledge:** | YES | NO |
|---|---|---|
| **1. Are you enrolled in Part A and Part B of Medicare?** | ☐ | ☐ |
| **2. Did you turn age 65 in the last 6 months?** | ☐ | ☐ |
| **Have you enrolled in Medicare Part B for the first time in the last six months?** | ☐ | ☐ |
| **If yes, you do NOT need to answer questions 7-20. If yes, please show date of enrollment (month/day/year)** | ___/___/___ | |
| **3.** Are you covered for medical assistance through the state Medicaid program? | ☐ | ☐ |
| **NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.** | | |
| If yes: | | |
| **a**. Will Medicaid pay your premiums for this Medicare supplement policy? | ☐ | ☐ |
| **b**. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? | ☐ | ☐ |
| **4.** If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start ___/___/___ End ___/___/___ | | |
| **a.** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? | ☐ | ☐ |
| **b**. Was this your first time in this type of Medicare plan? | ☐ | ☐ |
| **c.** Did you drop a Medicare supplement policy to enroll in the Medicare plan? | ☐ | ☐ |
| **5.** Do you have another Medicare Supplement policy in force? | ☐ | ☐ |
| **a.** If so, with what company and what plan do you have? _____ | | |
| **b**. If so, do you intend to replace your current Medicare Supplement policy with this policy? | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| **6.** Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) | ☐ | ☐ |
| **a.** If so, with what company and what kind of policy? _____ | | |
| **b.** What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank) Start ___/___/___ End ___/___/___ | | |
| **7.** Do you have a Chronic Lung Disease, Chronic Bronchitis, or Breathing Disorder? | ☐ | ☐ |
| **8.** Do you require the use of a walker? If yes, please explain _____ | ☐ | ☐ |
| **9.** In the past 12 months have you received medical treatment in an assisted living facility? | ☐ | ☐ |
| **10.** Do you have a mental disease or disorder requiring medication (including depression)? | ☐ | ☐ |

**NOTE: The answers you provide to questions 7, 8, 9 and 10 may not allow you to qualify for coverage. Height and Weight will be considered according to standard tables.**

| | | |
|---|---|---|
| **11.** Have you been hospitalized or confined to a nursing home within the past 90 days? Have you been hospitalized 2 or more times in the past 12 months? | ☐ | ☐ |
| **12.** Are you bedridden? Do you require the use of a wheelchair? | ☐ | ☐ |
| **13.** Do you have or have you been told by a medical professional that you have Alzheimer's Disease or Organic Brain Syndrome? | ☐ | ☐ |
| **14.** Have you been diagnosed as having, or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and /or AIDS Related Complex (ARC)? | ☐ | ☐ |
| **15.** Are you taking prescription drugs for **both** diabetes and a heart condition (including high blood pressure)? | ☐ | ☐ |
| **16.** Are you taking anti-coagulant (blood thinner) drugs? | ☐ | ☐ |
| **17.** Have you been advised by a medical professional that you may need surgery or a non-routine medical procedure within the next 12 months? (includes cataract surgery) | ☐ | ☐ |
| **18.** Within the past 2 years have you been diagnosed with, told by a medical professional that you have, or have you been treated for any of the following: | | |
| • alcoholism; drug addiction (or drug abuse); | ☐ | ☐ |
| • internal cancer; leukemia; malignant melanoma; | ☐ | ☐ |
| • congestive heart failure; valvular heart disease; coronary artery disease; heart rhythm disorder; heart attack; heart surgery (includes bypass, balloon surgery, or placement of an arterial stint); | ☐ | ☐ |
| • insulin dependent diabetes; systemic lupus erythematosus (SLE); | ☐ | ☐ |
| • multiple sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease; | ☐ | ☐ |
| • fractures or amputation caused by disease; degenerative bone disease; severe arthritis involving major joints (hip, knee or shoulder) or the spine; | ☐ | ☐ |
| • liver disease; chronic kidney disorder; kidney failure; kidney dialysis; | ☐ | ☐ |
| • chronic obstructive pulmonary disease (COPD) or emphysema; | ☐ | ☐ |
| • do you use oxygen; | ☐ | ☐ |
| • stroke; transient ischemic attack (TIA); | ☐ | ☐ |

**Note: If you answered "YES" to any of questions 11-18, you will not qualify for coverage.**

| | YES | NO |
|---|---|---|
| **19.** In the past 12 months, have you taken or been advised to take any prescription drugs, over the counter drugs, or medicines including narcotics, barbiturates or amphetamines? If "YES," indicate the specifics below: | ☐ | ☐ |

| Medication Name | Quantity Taken | Dosage | Prescribing Physician | Illness for Which Medication Prescribed | Date Last Prescribed |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**20.** Please provide us with the name, address and telephone number of the physician who has your medical records. If additional space is needed, use the Addendum to application AM5-1296.

| Name, address & phone number of Physician | Date & reason for last visit |
|---|---|
| | |
| | |

**IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

The Undersigned applicant and agent certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant _____

Date Application Completed _____ (Mo. Day Yr) Dated at _____ (City State)

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature. This policy ☐ does replace ☐ does not replace any insurance presently in force.

_____ Signature of Licensed Resident Agent(s)

_____ Signature of Licensed Resident Agent(s)

**TO BE FILLED OUT BY AGENT**

1. List any other health insurance policies you have sold the applicant which are still in force:

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force:

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
| *Company Tracking Number:* | | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *PHYS-125894661* | *State:* | *Arkansas* |
| *Filing Company:* | *Physicians Life Insurance Company* | *State Tracking Number:* | *40820* |
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| *Product Name:* | *ULA29AR-1 INFORMATION FILING* | | |
| *Project Name/Number:* | *ULA29AR-1 INFORMATION FILING/ULA29AR-1 INFORMATION FILING* | | |

# Supporting Document Schedules

**Review Status:**

**Satisfied -Name:** Certification/Notice 11/10/2008

**Comments:**

Please see certification/notice in SERFF filing #PHYS-125825381, State #40308 which was approved on 10/1/08.

**Review Status:**

**Satisfied -Name:** Application 11/10/2008

**Comments:**

Please see SERFF filing #PHYS-125825381, State #40308 which was approved on 10/1/08.

**Review Status:**

**Bypassed -Name:** Health - Actuarial Justification 11/10/2008

**Bypass Reason:** No rates associated with this filing

**Comments:**

**Review Status:**

**Bypassed -Name:** Outline of Coverage 11/10/2008

**Bypass Reason:** No change to the outline of coverage.

**Comments:**